Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN2101	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	07/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SMITHVILLE	825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies Based on observations, testing, and records review on 7/15/13, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.	N 002		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE M. Scott Hall TITLE Administrator (X6) DATE 8/7/13

AUG 08 2013